Fighting AIDS: Combatting the Discursive Construction and Neoliberal Governance of HIV Transmission

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INTRODUCTION

On March 17th, 1987, it was announced the United States Food and Drug Administration (FDA) had approved the first antiviral drug, azidothymidine (AZT), for the treatment of AIDS, or Acquired Immunodeficiency Syndrome. Pharmaceutical company Burroughs-Wellcome stated that it had been given a monopoly on the drug's patent, and its cost would be upwards of $10,000 annually for a single patient, making it one of the most expensive drug treatments in history (O'Reilly, 1990). By early 1987, almost 50,000 people had died because of complications from AIDS in the United States. Then current president Ronald Reagan had not mentioned AIDS in public, and would not for several more months (HIV.gov, 2019). Funding for AIDS research was minimal, especially compared to what the federal government spent on diseases that were far less threatening (Krieger, 1988). At the time, the AIDS crisis in the United States was still localized to large urban centers, specifically among young gay men. With the first real hope for People with Aids (PWAs) being placed at such a high price tag, the gay community's frustration at the government and medical establishment boiled over.

On the morning of March 24th, 1987, 250 protestors gathered in front of Trinity church on the corner of Broadway and Wall street in Lower Manhattan. United in anger, activists blocked traffic with their bodies and burned effigies of the FDA commissioner, Frank young (King, 2010). The group accused the FDA and Burroughs-Wellcome of forming an inequitable alliance and demanded an immediate release of all drugs that might help save the lives of everyone living with AIDS (Protest Flyer, 1987). Several weeks later, the FDA announced the speed-up of several other AIDS fighting drugs, with many crediting this to rallying cries from protestors.

A decade later in 1997, South Africa's legislature was in the midst of passing the Medicines and Related Substances Act (Heywood, 2015). The progressive law aimed to weaken the strength of pharmaceutical companies similar to Burroughs-Wellcome who were able to keep the price of antiviral drugs high through patents (Heywood, 2015). This law was met with extreme resistance by the pharmaceutical industry, who had a large backing from the United States government. ACT UP was at the forefront of demanding the Clinton administration disassociate from the desires of medical corporations, this time to profit off AIDS victims in developing countries. This newly formed alliance allowed activists in South Africa to drawn on ACT UP's arguments to help their own mobilization and fight to eradicate AIDS. On December 10th, 1998, a group of 15 activists gathered on the steps of St. George's Cathedral in Cape Town to challenge the South African government's complacency in the AIDS crisis that had assumed pandemic proportions. This initial protest, that called for universal access to ARVs for all people living with AIDS, grew into the Treatment Action Campaign (TAC), which continues to be the political might behind the fight for AIDS justice in South Africa.

The first protests by ACT UP and TAC were both groundbreaking acts of defiance against the lack of social, economic, and political support of PWAs in the United States and South Africa. Although activists were met with different sets of circumstances in these two very different geographies, their solidarity and retaliation illustrate the importance of understanding AIDS as a universal problem of political economy and discursive constructions.

While generally PWAs and grassroots campaign perceive AIDS as a consequence of political violence, global governance institutions and powerful national governments have historically disregarded this conclusion. Beginning in the 1980s in the United States, and continuing today in South Africa, mitigation efforts largely center individual responsibility as the

most effective way to stop human immunodeficiency virus (HIV) transmission, the virus that causes AIDS. This view is supported by the dominant biomedical framework that licenses AIDS as an inherently scientific problem, highlighting the need to understand patterns of biological behavior rather than the social context under which this behavior occurs. The popularity of biomedical individualism in public health circles intersects with neoliberal governance, which connects a decrease on government investment in the welfare state to the imagined natural desire for increased personal responsibility, free will, and self-care. Consequently, neoliberal institutions and government campaigns that have been at the forefront of HIV/AIDS mitigation efforts view PWAs as the reason for their own downfall because they are perceived to have full control over their agency. This framework is extremely dangerous because it ignores, and at the same time reinforces, powerful discourses that have cast AIDS as a disease of "the other", in this case the morally depraved, sexual promiscuous, gay and black bodies in the United States and South Africa, respectively.

This thesis explains why individual responsibility came to be the dominant framework for understanding and dealing with AIDS, and ultimately, why this approach is unsuccessful. By comparing two different places with two different histories, marginalized peoples, and social and economic makeups, I illustrate how in both cases, the disease is best fought by deconstructing derogatory representations of AIDS. I argue that in order to push AIDS away from this exceptional meaning, it is paramount to target specific neoliberal political and economic structures that perpetuate and intersect with AIDS individual, solely biomedical, and backward connotation.

I start by explaining the onset of the epidemic in the United States where, what would become known as AIDS, was first reported among homosexual men in 1981. From its fruition,

gay men made up a large proportion of PWAs, and consequently quickly established the disease as a gay plague, confirming AIDS as a disease of "the other." To better explain how the AIDS crisis assumed this discursive meaning, I take a socio-historical approach to reveal the gay community's position in American society before the epidemic, and how this influenced the community's response to being labeled as sexually promiscuous and victims of an inescapable curse. I then explain how this discourse intersected with the biological individuation of AIDS. By designating gay men as a group of summed individuals who were at high risk for infection, the medical community ripped the gay community away from their culture and history. The little emphasis placed on understanding how the gay community's social context influenced their behaviors reinforced the crisis as a consequence of moral failure. I use this as a point of departure to illustrate how this framing, one of individual blame and promiscuity, was in agreement with the ideology behind specific neoliberal political and economic policies that negatively affected funding for AIDS research. While proving how this framing is insufficient in stopping the epidemic, I use the AIDS activist group ACT UP as an example to instead argue that mitigating the HIV/AIDS epidemic in the United States was only possible because of direct action campaigns which challenged the discourses and political ideology that allowed the crisis to grow exponentially, and unaccountably, for years.

Shifting my analysis to South Africa, I argue that the current HIV/AIDS epidemic is a consequence of the continued subscription to neoliberalism and derogatory discourses that allowed the disease to flourish among othered bodies in the United States during the 1980s. Here, I am not suggesting that neoliberalism operates the same way in both countries, nor that the response by each national government was synonymous. Instead, by connecting past and present AIDS crises in the United States and South Africa, respectively, I crystalize my argument

that an individual, reductionist framework for preventing HIV transmission is unsuccessful and greater scrutiny of the political economy under which transmission occurs is required globally.

In South Africa, I craft my argument through problematizing the politics of prevention campaigns. Similarly to my discussion of the AIDS crisis in the United States, mitigation efforts diffused by international and local Non-Profit Organizations (NGOs), mirror neoliberal ideologies that center the individual as the cause of the epidemic. While again implementing a socio-historical approach to explain why groups most vulnerable to infection in South Africa are not to blame for their apparent "backward" actions, I illustrate how migrant and sex workers are unable to subscribe to the wishes of the World Health Organization (WHO) and the United Nations AIDS Foundation (UNAIDS) because of continued neoliberal economic development. In arguing that prevention campaigns fundamentally misperceive the root causes of the epidemic, I return to a discussion on AIDS activists, this time in South Africa to illustrate how the TAC political strategy, which was influenced in part by ACT UP, is the most successful way in erasing stigma and ending the AIDS crisis.

Throughout my paper, I rely on primary research from AIDS scholars to craft my argument. Specifically, I draw on the conclusions Didier Fassin (2007) makes in his book, *When Bodies Remember: Experiences and Politics of AIDS in South Africa*. Fassin articulates through a mix of ethnography, interviews with activists, and secondary historical sources, that understanding, and therefor ending, the AIDS crisis requires engaging with conflicting histories, intertwined global and local economies, representations and practices of PWAs, and the consequences of discrimination they produce (Fassin, 2007). Fassin rejects the typical ethnocentric, timeless, external perspective that is thought to be objective in preventing HIV transmission, and instead emphasizes the need for greater scrutiny of where transmission is

occurring, who is getting infected, and why certain representations of AIDS prevail over others (Fassin, 2007). Drawing from Fassin's research in South Africa, I employ his texts to argue that comprehending the epidemic as a combination of history, representations, and power relations, is useful in several different contexts. I also make use of Fassin's argument to detail the important implications the relationship between political economy and discourses have on the lived experiences of PWAs.

In conclusion, I hope to provide further scholarship that shifts the fight against AIDS away from one dominated by neoliberalism and negative discourses, and towards establishing a view of AIDS as what Fee and Krieger coined a "Collective, Chronic, Infectious Disease and Persistent Pandemic." By emphasizing AIDS as a collective rather than individualistic disease, socially determined rather than biologically sound, a consequence of political violence rather than individual choice, and an example of the power of anxious discourses rather than morally depraved people, I hope to continue the fight of AIDS activists to center the importance of combating HIV transmission through challenging a neoliberal political economy rather than fetishizing individual pathologies.

CHAPTER ONE: HIV/AIDS IN THE UNITED STATES

The Gay Community Pre-AIDS

To illustrate how the HIV/AIDS epidemic was constructed in the 1980s as a gay disease, it is necessary to understand the gay community's political and social makeup prior to 1981. Although when the AIDS crisis began cadaverous white gay men became the inescapable representation for all gay people, before and after AIDS hit, the queer community was never compatible with this characterization. Since trans women of color began to throw bricks at cops

during the Stonewall Riots in 1969, there had been increased queer activism throughout the 1970s. Gay and queer activists joined several other social justice movements that grew out of the anti-Vietnam war movement, calling for radical economic, political, and social change in the United States. Specifically, the main objective of the Gay Liberation Front and the Gay Activists Alliance was to eradicate all differences between straight and gay people, by fighting the stigma against queer people and gaining public recognition of the gay community (Padgug et Al, 1992). To do this, gay activist groups in the early 1970s linked themselves politically with the black and women's movement to fight persecution and discrimination by the state, police, and medical community, the latter of which listed homosexuality as a mental illness in the Diagnostic and Statistical Manual (DSM) until 1973 (DSM-II, 1968).

The anger and political achievements that grew out of the Stonewall Riots provided the gay community with safe places beyond bars and bathhouses. Consequently, political and social institutions that accepted, or tried to make sense of, the gay community as part of the "normal" world, allowed gay people to have larger visibility in popular culture (Adams, 1995). While liberation movements in big US cities also increased the number of gay bathhouses and bars, a new force between both sexual and asexual, political and social, gay places allowed the community to further its fight to decrease the exoticization of the gay community (Padgug et Al, 1992).

However, beginning in the late 1970s there was a shift in gay activism. This shift in politics was not only visible in the gay community, but visible everywhere as the left gained less power in American politics and an aggressive conservative party became appealing to many Americans. This new right-wing ideology emphasized the issue of "morality," and further politicized family values, women's rights, abortion, and homosexuality. Specifically,

homosexuality was used by right wing political and social institutions to argue that the gay community was a threat to the nuclear family, the most fundamental part of American society (MacKinnon, 1992). Similar to queer activism in the 1970s, far right Christian groups such as the Religious Roundtable and Christian Voices, fetishized the idea of a public gay world that could have its own identity and backing in the United States government (MacKinnon, 1992). In one way this was a win for the first wave of gay activists who wanted widespread recognition of the gay community. However, because of the political climate, this new expanded acknowledgment of gay people was met with negative attention. Once validated by mainstream politicians, increasing homophobia led to several religious groups starting campaigns to eradicate gay rights. For example, anti-Gay activists such as Anita Bryant ran successful campaigns in Florida and elsewhere that repealed laws that prohibited legal discrimination against gay people (Bryant, 1977). Widespread homophobic campaigns like these illustrated the power the conservative movement was gaining in the United States, and thus gay activists had to reposition their politics to best counteract increasing politicized homophobia. Instead of emphasizing the need for liberation and an end to all oppression by the state, gay activist groups began to subscribe to ideals of identity politics in order to protect their new minority group status (Padgug et Al, 1992). With the creation of The Gay National Task Force in 1977, gay activism began to emphasize the need for tolerance and assimilation of the gay community into society, instead of campaigning for human liberation and eradicating the difference between gay and straight (Padgug et Al, 1992). Although when the AIDS crisis began the gay community became marked as a singular entity and was met with little patience for understanding its' historical and social context, this political background had overwhelming implications for how the gay community fought AIDS and the discrimination that came along with it.

The Beginning of AIDS

When the AIDS crisis was first reported in 1981, it disrupted every aspect of the gay community and its multidimensional, contradictory makeup that prevailed for most of the 1970s. Since its onset in the United States, AIDS has always been closely linked to gay men, at one point so close that scientists named the disease "GRID" or Gay-Related Immunodeficiency Disorder, inferring that the immune system of gay people differed from those of straight people (Sontag, 1989). While there was in fact ample evidence of heterosexual's contracting AIDS as early as 1981, the blatant avoidance of these cases illustrates how in the early years of the epidemic the scientific community was unable to fathom the disease as something bigger than gay men, and thus treated the disease as something that was being perpetuated by certain characteristics of certain people (Shilts, 1987). The fascination with AIDS as a gay disease can also not be separated from gay men's' reputation in the 1970s as being sexually promiscuous. Men having sex with other men in public bathhouses became synonymous with the "gay lifestyle", although this only characterized a small portion of the community. The medical and popular representation of all gay men as sexually barbaric, furthered the argument that AIDS was a disease caused by specific, depraved actions. This discourse permitted scientists to study the disease as inherently indicative of gay men's sexual relationships, reestablishing the connection between homosexuality and illness, and consequently forgetting the social and political context that propelled gay men to originally start having sex in bathhouses (Padgug et Al, 1992; Sontag, 1989). The construction of AIDS as a gay disease was further cemented when epidemiologists categorized gay men as a "high-risk" group for transmission. While gay men were a large portion of AIDS victims, this label designated the whole gay community as sick and plagued because of

their sexual lives, further distancing them from the rest of society and establishing AIDS as an issue of morality (Fee et Al, 1993).

The conservative movement also played a pivotal role in the construction of AIDS. As previously mentioned, in the 1970s there were numerous local movements that sought to "save our children" from the growing gay liberation movement (Bryant, 1977). When AIDS was first discovered, the right wing quickly used the diseases' prevalence in the gay community to prove how homosexuality was unnatural and threatening (MacKinnon, 1992; Fee et Al, 1993). They explained the disease as a consequence of declining traditional values in the face of ravenous and selfish social justice movements during the1970s, drawing all attention away from the disease as something scientific but instead a difference between purity and pollution (Sontag, 1989). Several scholars, including Elizabeth Fee, Nancy Krieger, and Susan Sontag explain how this representation of the disease allowed for a fantastical obsession of AIDS as one of an inescapable, all-encompassing plague that echoed the fears of past diseases like yellow fever and the Black Death (Fee et Al, 1993; Sontag, 1989). These fears were perpetuated by the media, that would only discuss AIDS as a "gay plague." This title helped to keep anxieties at bay about AIDS and authorized the disease as something that could be contained outside of the heterosexual world. This discourse casted AIDS as a disease of "the other" that would only exist in the inner cities among homosexuals, and thus could be tolerated as long as only those people died (Fee et Al, 1993).

The above examples illustrate how the dominant discourse about AIDS quickly became one of moral depravity, sexual promiscuity, and backwardness of Gay Men. The discursive power of AIDS left the gay community in a difficult situation. On one hand, accepting their label as a sick population would erase all progress the gay community made in the 1970s to eradicate

the perception of difference between gay and straight people, spiraling the community into isolation and hostility. However, because it was evident the "normal" heterosexual population of the United States was unconcerned with trying to understand AIDS, the gay community distancing themselves from the epidemic would lead to AIDS being ignored and countless deaths to continue. (Padgug et Al, 1992). Consequently, the Gay community had little choice but to accept AIDS as their disease in order to save members of their community.

Unlike the dominant discourse that presented AIDS as a plague, the gay community could not accept common metaphors of AIDS that separated the disease from its reality as a serious and undiscriminating public health threat. The gay community, and gay men specifically, were forced to normalize the epidemic and humanize the deaths of gay men, who were viewed as the unforgiving culprits of the epidemic, to illustrate how AIDS was not a consequence of deviant sexuality (Fee et Al, 1993). By doing this, the gay community could begin to control the social implications of the disease and take steps to reveal AIDS to be a scientific and universal problem (Padgug et Al, 1992). Thus, just like the scientific community and conservative movement, the gay community helped to construct AIDS as their own, gay disease.

The Individuation of AIDS

Another important category that reveals why AIDS was quickly framed as a gay disease, is the individuation of the epidemic; or how AIDS was examined under a medical framework that isolated the individual from its surroundings.

By the 1970s, there was increasing consensus that controlling diseases, specifically chronic disease, was most effective through changing individual behavior (Fox, 1988). This is the general assumption underlying most biomedical models that urge individuals to take more responsibility for their health, inferring that individual people are most responsible for their

individual problems. In turn, this increased attention on the individual led to increased victimization and further isolation of patients from their social and economic lives (Fee et Al, 1993). Fee and Krieger argue that this is because individual biomedical models are largely reductionist and center the problems of medical intervention that are narrowly constructed and ignore societal factors (Fee et Al, 1993). Instead of assuming people having personal and social relationships, this paradigm infers all that is needed to control diseases is medical intervention, focusing on medical mechanisms (Fox, 1988). Most importantly, there is no analysis on how someone's socioeconomic status and community affects there sexual and recreational behaviors, and instead assumes the individual is able to make the best health decisions. Thus, this biomedical model views sub groups, and even "high risk" groups as people separate from culture or history, and only high risk because of their biological make up (Fox, 1988). This conclusion is problematized by Fassin, who argues that defining gay men as a risk group for contracting AIDS only reestablishes preexisting social stigmas of homosexuality, instead of inventing any new biological discoveries (Fassin, 2007).

In line with Fassin's critique, this model struggled to help understand why gay men were disproportionately dying from AIDS. Counterintuitively, this biomedical model affirmed popular discourses that there was something inherently wrong with the immune systems of gay men, allowing AIDS to continue existing as a consequence of individual action and promiscuity. Although different from how AIDS was covered in the media, the dominance of an individual model in medicine led to scientists focusing on AIDS as nothing more than a biological problem of a certain set of people. Consequently, the political, social, and economic context under which gay men were being infected was not take in account, and conservative commentators were able

to continue their rhetoric of AIDS as a result of deviance instead of technicality, with the backing of the scientific community.

I have argued that the framing of the AIDS crisis in the early 1980s was predominantly one of promiscuity, the gay plague, and individual blame. The dominant representation of AIDS as a gay disease cemented quickly in popular culture and helped to quell anxieties about the epidemic spreading. As a result, this discourse strengthened the divide between the gay community and the rest of society, reflecting the new right's position that gay men were a threat to the United States. At the same time, understanding the epidemic from a medical perspective grew out of a dominant biomedical model that centered the individual's biological make up as separate and more important than its social surroundings. While these things are contradictory in nature -how the disease was constructed as one of a large group of people but only studied body by body- these two overarching themes worked together to exacerbate the epidemic. The discourse that AIDS is an inevitable result of deviance is justified by the medical individuation of AIDS that focuses on the actions of individual people, and thus reveals AIDS in popular culture to be a punishment for the sin of deviance. Most importantly, the discursive power of AIDS had tangible consequences for PWAs and intersected with specific political and economic policies to aggravate the epidemic. These discourses helped fuel the political-economic response to the AIDS crisis in the United States, which centered on shifting blame and financial responsibility for the illness on to stigmatized individuals, while leaving the federal government and privatized health care industry to maximize profits.

The Government's Response amongst a Changing Global Order

The discourses that surrounded AIDS in the 1980s intersected, and grew out of, the political and economic position of the United States. Jean Comaroff explains that the AIDS

epidemic came about at a time of a changing global order, in a world "high on the hype of Reaganomics, deregulation, and the end of the Cold War." (Comaroff, 2006). Furthermore, Fee chronicles how AIDS fit nicely into the anxieties of a changing world. When the AIDS crisis began, progressive social movements were beginning to fragment, debt crisis and high unemployment engendered much of the free world, and the USSR was beginning to sever, leading to untold anxieties about what could come with the creation of dozens of new countries (Fee et Al, 1993). AIDS fit nicely into this overwhelming sense of catastrophe, and its' arrival in correlation with a changing geopolitical and social world had profound impacts on how the epidemic was handled.

In order to understand the federal government's response to AIDS in the 1980s, it is essential to analyze the political and economic context that AIDS research and prevention campaigns were functioning within. When Ronald Reagan was elected the 40th president of the United States in 1980, "star wars" militarism, trickle-down economics, and traditional family values took center stage in the political world (Brier, 2009). Reagan's political, social, and economic positions were seen by many as strong answers to the previously stated anxieties about the world that consumed much of the media, including AIDS. To successfully save the country from the Supreme Court's 1973 decision on abortion, increasing visibility of gay activism, and military decline in the face of Soviet Power, Reagan developed a new political strategy (MacKinnon, 1992). Instead of subscribing to norms of Keynesian economics that began to fall apart in the 1970s, Reagan stressed competition as the definition of human relations, casted people as nothing more than consumers, and individualized success to merit productivity over mental health. Reagan's commitment to cutting taxes and the welfare state, reducing government spending on health care, and shifting safety and health regulations to private enterprises, were all

center to his political strategy to take responsibility away from the government and put great emphasis on the economic market (Brier, 2009). As the Reagan presidency and AIDS crisis continued side by side, Reagan's economic and political conquests perpetuated the epidemic, while at the same time ignored its existence. This is clearly seen in Reagan's quest for military expansion at the cost of social services. Between 1982 and 1986, military spending increased by 38 percent while federal funding for health services decreased by 8 percent (Krieger, 1988). Similarly, funding for education and housing decreased by 14 and 82 percent, respectively, two issues that are critical to PWAs (Krieger, 1988; Fee et Al, 1993). Additionally, in 1987 the pentagon had over 270$ billion in *unspent* funds, a number nearly twice the amount Reagan budgeted for health and Medicare services, reflecting the administration's desire to cut Medicare services, something a majority of AIDS patients relied on (Krieger, 1988).

These political and economic policies can also not be separated from the discourses that licensed AIDS as a disease of promiscuity and individual responsibility. Reagan's win illustrated how the new right was overwhelmingly the dominant party in American politics. As I have already discussed, the new right's increase in popularity had been noticeable since the late 1970s, when far right Christian political groups helped to diffuse ideas of the United States falling victim to moral inadequacies of the imagined modernizing, progressive world (MacKinnon, 1992). Reagan's association with the new right required a moral stance against gay rights, giving little hope from the beginning that the epidemic would be taken seriously by the administration (Brier, 2009). Bronski explains how Reagan understood that a large part of maintaining his power required pleasing his Christian, republican, and conservative base. This base included people like Patrick Buchanan, who in 1983 wrote in the *New York Post* that gay men have "declared war upon nature, and now nature is exacting an awful retribution" (Bronski,

2003). The power these discourses held over the Reagan Administration were paramount. Further evidence reveals that in 1983, The department of Health and Human Services (DHHS) declared that AIDS was the United States' number one health priority (Krieger, 1988). Despite this, by the end of 1986, funding for AIDS research and prevention was only 4 percent of the federal health budget (Krieger, 1988). This illustrates how the Reagan administration's AIDS policies were grounded within Reagan's broader political agenda to slash social services and expedite responsibility to the private sector, while also increasing military spending.

Outside of Reagan's implementation of neoliberal policies, the Christian right had a large influence on the federal government's response to AIDS. Because the moral majority was an important part of Reagan's political prospects, the administration pursued this course in part because of its construction of AIDS as a gay disease. This is evident among Reagan's cabinet, who wanted AIDS education to fit the model of social and religious conservatism that posted gay men as sick and dangerous (Brier, 2009). Several congressmen, including Newt Gingrich, came up with a "commonsense" response to AIDS where they argued that closing bathhouses or mandated reporting of AIDS was the best way to deal with the illness, illustrating their desire to make the public healthy by restricting the civil rights of those constructed as being plagued (Brier, 2009). Mariam Bell, director of religious affairs in the Office of Public Liaison, even tried to publish a book titled *Homosexuality: Legitimate, Alternative Deathstyle*. The book linked homosexuality to crime, specifically child molestation, reiterating the Christian's right desire to protect "normal" people from AIDS by discriminating against the gay community (Brier, 2009).

The federal government's view on the epidemic also fit nicely into Reagan's concept of "free will," where the individual was seen as the master of their fate, and thus the reason for their downfall. As a consequence of the individuation of AIDS and its association with some of the

most stigmatized groups in the United States, the idea that the government shouldn't have to pay for the health care of gay people, who brought the disease on themselves, was commonplace (Krieger, 1988). Similarly, because the biomedical model led to an almost exclusive focus on HIV and its biological determinants instead of the social determinants of its transmission, policy makers under Reagan argued that health agencies would overstep their boundaries if they applied political solutions to a health problem (Fee et Al, 1993; Brier, 2009). Ironically, although perhaps not "political" for the Reagan administration, it was obvious the government's response was rooted in conservative political ideology rather than public health policy. While looking at the political economy of inner cities, the war on drugs, and the oppression of gays could be seen as controversial and political, studying human cells and promoting heterosexual marriage was much more in line with the traditional, American values Raegan campaigned on (Krieger, 1988). Thus, instead of focusing on educating the public on AIDS, which even Reagan's surgeon general, Everett Koop, argued was the most effect way to stop the epidemic, the federal government promoted a moralistic, repressive, and divisive AIDS program.

When Reagan approved the creation of the National AIDS commission in 1987, 6 years after the epidemic started and after 27,000 deaths alone in the United States, the agency promoted traditional family values, heterosexual marriage, and individual responsibility as central to national policy (Bronski, 2003; Brier, 2009). As a consequence, funding for AIDS research continued to disappoint as the epidemic was not centered as a scientific problem. In 1987, $126 million was allocated for AIDS research in the department of Health and Human Services (HHS), only .08 percent of HHS's total $1.5 billion budget (Krieger, 1988).

In short, Reagan's response to the AIDS epidemic was indicative of his neoliberal political strategy to decrease social welfare services, increase military spending, and place

greater responsibility on the individual for their own well-being. Reagan's political and economic policies collided with the construction of AIDS as a gay disease and moral depravity, which had tangible consequences for AIDS research. The discursive construction of AIDS intersected perfectly with Reagan's neoliberal agenda to center individual responsibility as the dominant framework for understanding the AIDS crisis. This representation allowed the epidemic to continue as one of individual pathologies separate from their social surroundings.

ACT UP

While funding for AIDS research continued to suffer from the federal government's insistence on individual responsibility and moral empowerment, AIDS activists and victims of the epidemic addressed the crisis through different means.

The AIDS Coalition to Unleash Power (ACT UP), began in New York in 1987, and quickly became the political opposition to the Federal Governments inept response to the AIDS crisis (Brier, 2009). Initially, the group drew exclusively from organizations that were leaders in the gay liberation movement during the 1970s, specifically the National Gay and Lesbian Task Force and the Gay Rights Lobby (Halcli, 1999). Here, former activists could unite in anger and embrace their radical sexual politics. The formation of ACT UP also reiterated the gay community's acceptance of AIDS as their disease, illustrating their commitment to challenging cultural constructions of the epidemic and fighting to create a positive identity for all AIDS victims (Halcli, 1999).

From its foundation, ACT UP viewed the AIDS crisis completely differently than the United States government. This is best illustrated in 1989 when ACT UP members stormed the Fifth International AIDS Conference in Montréal. Here, activists presented a manifesto that demanded universal healthcare for all people living with AIDS, the identification of poverty as a

cofactor of HIV transmission, and a conversion of military spending to medical health and basic social services (Brier, 2009). This manifesto highlighted ACT UP's political strategy in emphasizing the need to understand the larger political and economic context from which the AIDS crisis emerged (Brier, 2009). This required creating solutions that addressed the relationship between AIDS, homophobia, and economic discrimination that made certain bodies more likely to contract HIV. Consequently, ACT UP worked to increase public awareness on the social effects of AIDS and called for an end to homophobia, racism, sexism, and the gulf war (Halcli, 1999). This critique of the political economy of the United States was echoed through chants such as "Act up, Fight back, Fight AIDS and not Iraq," and ACT UP's involvement with the Majority Action Committee and The Women's Caucus (Halcli 1999; Brier, 2009).

ACT UP was also influential in giving HIV positive people "a place at the high table" (Goldberg, 1998). Former ACT UP activist Ron Goldberg, who was present at the Montreal Manifesto in 1989, writes that before the conference people living with AIDS were "presented mainly as abstractions… reduced to statistics on spreadsheets, their needs and desires mere sidelights to the noble pursuit of science" (Goldberg, 1998). ACT UP members like Goldberg challenged the idea of biomedical individualism that designated scientist as the sole producers of knowledge on HIV/AIDS. To combat this discourse and to demand the federal government and pharmaceutical companies come up with more treatment options, ACT UP formed the Treatment and Data Committee. The committee recognized that only when people living with AIDS could control the course of their own treatment would scientists change the way they produced drugs (Brier, 2009). ACT UP was essential in allowing PWAs to assume a place next to scientists and researchers, and consequently, pushing the medical community to design drug trials that were applicable to the real world (Goldberg, 1998). For example, within two weeks of a protest at the

FDA headquarters, the institution changed its regulation to allow for a speeded-up drug evaluation process (Brier, 2009). In correlation with demanding faster drug trials, ACT UP fought against the expensive price tag on HIV medication, arguing that even if treatment was available it did little for people who could not afford it. This was a difficult task because pharmaceutical companies had successfully lobbied the government to create patents for drugs still in development, revealing the private health care industry's wish to maximize profits on people dying from AIDS. Although this increased pharmaceutical companies' ability to keep the price of drugs high, ACT UP was still successful in lowering the cost of drugs like AZT, through continued demonstrations and highlighting the connection between social vulnerability and HIV transmission (Halcli, 1999).

ACT UP's recognition of AIDS as a political problem due to the chronic underfunding of AIDS research and the Reagan administration's refusal to invest in sexually explicit AIDS prevention programs was paramount in changing cultural perception on both gay rights and AIDS (Halcli, 1999; Brier, 2009). By highlighting the structural inequalities that perpetuated the epidemic, activists were able to push back on discourses that imagined AIDS as the punishment for sexual deviancy.

Throughout the late 1980s and early 1990s, ACT UP served as the basis for political opposition to the United States anti-AIDS efforts. ACT UP provided a different framework for understanding the epidemic, one that required greater scrutiny of the political economy of the United States and a stronger critique of the scientific community. By linking together issues of poverty, the power of pharmaceutical companies, racism, homophobia, and military spending, ACT UP illustrated that the AIDS epidemic would always exist if individual blame and morality continued to be the dominant stance taken by the government. ACT UP's perception of the

epidemic as a result of derogatory popular discourses, neoliberal economic policies, and an individual medical framework, carries important implications on how the epidemic can be mitigated in other countries.

From Gay to Black Plague

Now in the United States, being HIV positive is no longer a death sentence. While stigma is still rampant, people can live with HIV, in part because of the activism of dying gay men and allies in the 1980s and 90s. While I have argued that ACT UP's approach to the AIDS crisis, which centered the issues of universal health care, gay rights, and class inequality, was a more successful approach than the Reagan administration's view of AIDS as an individual diagnosis of moral depravity, this approach should not be isolated to the United States.

Although it has been almost four decades since the epidemic began, the same discourses that dominated AIDS in the 1980s are embedded in the institutions that are seeking to cure AIDS in South Africa. Comaroff writes how the most devastating geographies of the HIV/AIDS pandemic have shifted outside of the West to where, from the vantage of the United States, "misery is endemic, life is cheap, and people are disposable" (Comaroff, 2007). To those in the United States, AIDS fits nicely into the construction of Sub-Saharan Africa as a place where people are doomed, abject, and intractable. Since Joseph Conrad published his account of traveling up the Congo River in 1899, the heart of Africa has been illustrated as a disease-ridden place, where it makes sense to see mass-media images of genocidal leaders, refugee caravans, and schools turning to orphanages. The placing of AIDS among these images has calmed our anxieties, letting the epidemic slip from consciousness in the United States, despite rates of HIV transmission in the African American community increasing (CDC, 2017; Poku, 2002).

CHAPTER TWO: HIV/AIDS IN SOUTH AFRICA

Changing the Epicenter of the AIDS Crisis

The continued discourses of perversion and shame surrounding AIDS and the view of Africa as a homogenous, hopeless mass, mirror the current state of the HIV/AIDS epidemic in Southern Africa. Of the total 36.7 million people who are living with HIV worldwide, 50% reside in East and Southern Africa, a region home to only 6.2% of the world's population (UNAIDS, 2018). These circulating discourses of Africa being inherently "less than" coupled with large-scale public health catastrophes have reinvigorated images of Europe as savior, civilizer, and philanthropist to the African continent (Comaroff, 2007). For example, these concerning statistics have attracted the attention of international NGOs to try to stop the dizzying rates of infection. The United Nations AIDS foundation (UNAIDS,) has even pronounced ending HIV/AIDS as a public health threat by 2030 as part of their Sustainable Development Goals (SDGs,) a set of 15 goals the UN has established to save the world (UNAIDS, 2018).

The dominant discourse among these organizations, like the UN and the World Health Organization (WHO,) frames the disease as result of individual behavior. Although different from the language of the Reagan administration that demonized individual carriers of AIDS, NGOs and national government campaigns advocate for things like condom use and awareness about the disease as the most powerful tools to stop the epidemic. Although awareness and safe sex are important, these policies still fail to consider the implications larger structural problems in the region, such as extreme inequality and entrenched labor migration, have on perpetuating the disease (Comaroff, 1993; Hickel, 2012; King, 2017). This is evident as States and NGOs have spent billions of dollars diffusing condom promotion programs and behavior change

interventions, but little to no progress has been made in reducing rates of infection. In South Africa HIV infection among women attending antenatal clinics has risen from less than 1 percent in 1990 to over 30% in 2015 (South Africa: Department of Health, 2017). Today, South Africa has the biggest HIV epidemic in the world, with 7.1 million people living with HIV and roughly 20% of the population (Avert, 2018). Current day prevention methods that continue prevention strategies from the 1980s, and consequently ignore the problems of the political economy under which HIV transmission occur, are unsuccessful.

In this section I aim to explain the current HIV/AIDS epidemic in South Africa as a consequence of the continuation of neoliberal economic policy and derogatory discourses that dominated AIDS politics in the United States during the 1980s. Specifically, I focus on the changing construction of AIDS from a gay plague, to a black plague perpetuated by migrant and sex workers (Poku, 2002). I trace the effects the legacies of colonialism and neoliberal development portfolios have on creating entrenched labor migration and extreme inequality in the region, resulting in HIV existing as a disease that is outside the control of its victims, and instead is perpetuated by specific neoliberal economic and political structures in South Africa. By revealing the disease to exist in the region as a result of the political economy of South Africa, rather than individual pathologies, I analyze the strategy of the Treatment Action Campaign (TAC) to provide another, more successful mitigation framework. Here, I connect the strategies of the TAC to ACT UP's. By illustrating how the shared solidarity between the two organizations allowed for the TAC to integrate ACT UP's strategy in to their activist movement in South Africa, I continue my argument that derogatory discourses surrounding AIDS also intersect with specific economic and political structures in South Africa. Thus, ending the AIDS

crisis requires activist movements that challenge neoliberal ideologies and policies that perpetuate the derogatory construction of AIDS.

I am not arguing that neoliberalism is a singular, totalizing entity that rooted itself similarly in South Africa and the United States. Nor do I want to humor the idea that Reagan's moralistic, homophobic, and classist response to the epidemic is similar to Mbeki's denial of the link between HIV and AIDS. As a consequence of different neoliberal interactions and government responses, I am also not arguing that the lived realities of PWAs are synonymous in the United States and South Africa. However, by connecting the HIV/AIDS epidemic in these two very different places, I strengthen my argument that an individual, neoliberal framework is universally insufficient in reducing rates of HIV transmission. I hope to crystalize my efforts to illustrate how discourses surrounding AIDS, and the neoliberal institutions that perpetuate them, are best fought by AIDS activist who problematize the social, historical, political, and economic settings of HIV transmission to bridge the gap between individual pathology and political economy.

Creating the Perfect Storm for HIV Transmission in South Africa

Similarly to understanding the construction of AIDS as a gay disease in the United States, it is important to take a socio-historical approach to understand the current framing of the HIV epidemic in South Africa. Although in the United States the derogatory imagination of AIDS can be traced back to the gay liberation movement in the 1970s, the construction of HIV as a disease of individuality and backwardness of certain peoples in South Africa is a legacy of cultural and political discourses that were authorized by European colonialism in the 19th century (Comaroff, 1993). European colonialism created a visible racial hierarchy, and as a consequence its legal framework established an extensive black labor migration system and extraordinary class and

racial divides (King, 2017). These structural problems are still sprawling today and are allowing HIV transmission to flourish but are largely forgotten about in prevention campaigns diffused by neoliberal governing bodies.

Although economic benefit was the primary driver of colonization, early missionaries had a genuine interest in saving the black body by leading them towards European enlightenment, a process known as humane imperialism (Comaroff, 1993). At the same time, this mission to civilize created a distinct binary between us and them, where Europe came to embody health and knowledge, and Africa was left to personify disease and unconsciousness. This racial hierarchy is well documented in 19th century scholarship on the black body, which characterized the whole of the black race as the link between man and ape, exhibited the genitalia of black women as mythological and exotic, and connected the evolution of the African body to the putrid and impoverished African climate (Comaroff, 1993). This form of scientific racism was an important hegemonic tool used by Europeans to maintain political and economic control over Africa, and accordingly translated into tangible consequences for Africans during the late 19th century, when labor migration became a cornerstone of South Africa's political, economic, and social world.

After the "mineral revolution" commenced in South Africa during the 1860s, European colonists depended on black labor to continue the increased flow of capital back to Europe (Comaroff, 1993). To coerce Africans into migrant labor, colonists began restricting African peoples' access to arable farmland and imposed taxes on households, making subsistence agriculture insufficient to survive (Hickel, 2012). Because the colonizers recognized Africans as fundamental to the South African economy, public health policies became an important tool to naturalize the separation of natives from white society (King, 2017). Drawing from the legacies of humane imperialism that licensed African anatomy as a center of disease, colonial public

health policies racially segregated cities to ensure the plagued black body would not infect white bourgeois neighborhoods (Comaroff, 1993). Beginning in 1872, the Colonial Government began implementing these racist and restrictive laws, forcing black migrant workers to commute back and forth between urban work camps and their rural homes. These laws also allowed mining companies to pay their black migrant workers less than settled white urban workers, creating a noticeable, racial class divide (Hickel, 2012).

The laws that would eventually translate into South Africa's fascist and apartheid state, allowed European capitalists to successfully make native South Africans dependent on circular migrant labor, a system that is sprawling over a century and a half later. In 2012, South Africa accounted for about 16 percent of Swaziland's formal employment, and 36 percent of Swazi households stated that at least one family member worked in South Africa (Hickel, 2012). Another study in 2003 revealed that 2.5 million migrants came to work in South Africa illegally per year, suggesting that statistics on labor migration are much higher than state census' can reveal (Lurie, 2003). Fassin chronicles how in many ways "HIV/AIDS was a pandemic waiting to happen", because the social context of work-related migration multiplied high-risk situations exponentially, and yet were not analyzed as contributors to the epidemic by international public health circles (Fassin, 2007). The colonial political economy of South Africa that divided the whole of South African society illustrates how the socio-historical construction of marginalized groups pre-AIDS had tangible consequences on the ability of vulnerable individuals to control their agency. Those groups that were most marginalized and stigmatized in the past, are now at the highest risk of HIV transmission.

The working and living conditions of migrant workers are treacherous and create a context where HIV infection is inevitable. Connell reveals how in Johannesburg, migrants work

for six days a week, twelve hours a day for 120$ a month, less than half the legal minimum wage in South Africa. If workers try to argue for better wages, they face being beaten, tortured, and kidnapped (Connell, 2016). To stop workers striking for an increased wage, as well as to combat oppressive working conditions that produce alarming rates of injury, workers are given alcohol and prostitutes to keep their spirits up (Connell, 2016). These practices are opposite to HIV prevention methods preached by UNAIDS and The World Health Organization. Although transactional sex is inseparable from migrant work camps, workers living in illegal settlements rarely have access to public health care, resulting in little to no access to antiretroviral therapies and condoms. The risk of having untreated sexually transmitted diseases (STIs), coupled with not having access to antiretroviral therapies, increases the risk of HIV transmission by up to 400 percent, creating a perfect storm for the HIV epidemic (Hickel, 2012). Today, migrant work camps exhibit some of the highest rates of HIV infection in the world: Gold mines in South Africa reveal 50 percent of workers are HIV positive, and Zimbabwe Sugar Plantations illustrate rates upwards of 70 percent (Hickel, 2012).

A Neoliberal Africa

Although these livelihoods seem unbearable, workers have no choice but to stay in the mines because of little economic opportunity in South Africa. This is partly because of large-scale economic reform programs conducted by the international monetary fund (IMF) and the World Bank during the 1980s and 90s throughout much of the developing world (Rowden, 2012). These structural adjustment programs (SAPs) mirrored Ronald Reagan's domestic neoliberal economic policies, through freeing trade policies that cut subsidies and tariffs, privatizing state enterprises to increase market efficiency, and diminishing returns on small-scale farming to favor corporate agri-business (Rowden, 2012.) Thabo Mbeki, the second

democratically elected president of South Africa, pursued these policies to integrate South Africa into the global economy (Magubane, 2004). Although the African National Congress (ANC) was at first hailed for its revolutionary policies, Mbeki's economic strategy embraced privatization, free enterprise and free markets (Magubane, 2004). Similarly, South Africa's Growth, Employment and Redistribution Plan (GEAR) downsized the cost and size of the public sectors, and as a result slashed funding to education, social welfare, and health services, all extremely relevant in the world of AIDS (Saul, 2001).

Ronald Reagan and former British Prime Minister Margaret Thatcher marketed their conservative political strategy as an innovative, efficient, and natural way of bringing development and modernity to the world's poorest countries. In this regard, it makes sense that Mbeki wanted to work consistently to strengthen economic relations between South Africa and Europe (Magubane, 2004). However, the reference to a new form of economic liberalism invokes a connection to the 19th century economic policies that dominated European imperialist efforts, inevitably authorizing neoliberalism as a continuation of colonial economic policy that serves to extract wealth from the poorest countries to the capitalist core in the Global North. Therefore, it is not surprising that instead of granting wealth and innovation, these policies quickly translated into an economic disaster for South Africa. Between 1994 and 2002, one million South Africans lost their job in the formal sector, and in 2002, 32 percent of the labor force was unemployed (Cronin, 2002). In total, Sub-Saharan Africa's global merchandise exports have decreased from 4.5 percent in 1980 to 1.4 percent in 2001, and all together the region's balance of trade fell by 50% between 1980 and 1998 (Rowden, 2012). Between 1981 and 2009 the number of people living on less than one dollar a day in the region doubled from 164 million to 314 million, illustrating one consequence of the 13 percent decline in sub-Saharan Africa's

Gross Domestic Product (Rowden, 2012). This is in stark contrast to South Africa's privatization proceeds of 40 Billion Rand, about $2.7 Billion U.S. Dollars, between 2001 and 2004, confirming that neoliberalism helped continue high levels of wealth disparity and inequality that were present during the apartheid regime (Mugabane, 2004).

In the 21st century, the World Bank and IMF continue to conduct economic reform programs in South Africa under the more humanitarian sounding title of Sustainable Development, which they conclude will end poverty and boost prosperity for the poorest people, while also protecting the environment (World Bank, 2018). Although these policies are marketed as the solution to the world's most pressing problems, sustainable development is synonymous with the neoliberal economic reform programs detailed above, consequently increasing poverty and continuing wealth disparity into the 21st century. Here, derogatory discourses are diffused, embedded, and justified by legacies of colonialism that influenced the rise of neoliberalism, and mirror the same language that othered gay men in the 1980s. In fact, neoliberal governing programs that claim to promote development continue to characterize African culture as backward and barbaric, the same language that justified the need for black labor migration and racial class divides (Basu, 2004). For example, the U.S. Agency for International Development (USAID) has stated one primary reason for not distributing HIV antiretroviral therapies in the developing world is because poor persons cannot adhere to the complexities of western medicine, and instead are better suited to practice abstinence and faithfulness (Basu, 2004). Other NGOs have expressed concern that infrastructure in poor countries is not modern enough to support complex HIV drug prevention measures, concluding that Africans would improperly take the drugs and create drug resistant forms of HIV (Basu, 2004). This language epitomizes the purpose of the individual biomedical model, and reiterates early scholarship on scientific racism

that situates knowledge in the hands of the Global North which they cannot give to the Global South because they are un-modern and unwilling to do away with their taboo cultures. Scholars have also helped construct Africans as oversexualized, stating that the AIDS crisis could be mitigated if "they could control their sexual cravings" (Poku, 2003). This language is similar to discourses that casted gay men as sexually promiscuous in the 1980s, inferring that there is something inherent about gay and African culture that makes them more likely to contract sexually transmitted diseases.

The structural adjustment programs that commenced during the 1980s and have since become synonymous with neoliberal institutions of the 21st century, have created dire circumstances for South Africans, whom the USAID and World Bank refuse to consult while defining problems and creating solutions for development that are taking place in their own country. Consequences of neoliberal governance such as the devastation of local industries, food insecurity, restrictive workers' rights, and the inability to survive from rural farming because of agricultural liberalization, reveal why migrant labor is crucial for many workers, and their families, to survive (Rowden, 2012). In Swaziland, 72 percent of disposable income for poorer families comes from migrant worker's remittances in South Africa and 80 percent of these households have no other form of disposable income (Hickel, 2012). Women's high dependency on their partner's incomes coupled with no ability to find stable employment, leads to many women engaging in transactional sex. Women are not blind to their partners infidelity, and in open ended interviews, women actually found the questions regarding their husbands' monogamy funny, stating that additional sexual partners was a "truism" of migration (Lurie, 2003). Despite this, 79% of women in this study reported that they did not use a condom in their last sexual encounter (Lurie, 2003). Although the World Bank might argue this is an example of

Africa's backwardness, unprotected sex is more because of a dire need to eat and have shelter, stemming from the inequality perpetuated by neoliberalism (Rowden, 2012). Because of female dependency on male wealth, women cannot easily negotiate condom use in fear their client will not pay them adequately, money they quite literally need to survive. These circumstances of wealth and gender inequality make sex workers highly susceptible to HIV. In South Africa, 57% of sex workers are HIV positive (Avert, 2018). The shocking rates of HIV among migrant workers and sex workers reveal that neoliberal development programs do nothing to fight the HIV epidemic, but rather deepen the structural problems that perpetuate the disease.

Although the livelihoods of people living with HIV makes it obvious that vulnerable victims do not have a choice to change their behavior; that they are forced to prioritize more immediate risks like starvation and poverty over the risk of HIV infection, prevention campaigns largely refuse to address these problems. Not surprisingly, because neoliberalism dominates the region, prevention campaigns echo strategies in line with neoliberal development, and in particular the same concept of free will that was used to deny health care to gay men dying of AIDS throughout the 1980s in the United States. This reductionist, level-the-playing-field ideology, has resulted in prevention campaigns promoting interventions that change individual behavior. The National Emergency Response Council on HIV and AIDS (NERCHA,) prioritizes monogamy, abstinence and fidelity as the best ways to prevent the epidemic, while WHO presents comprehensive sexuality education and cutting economic barriers to condoms (NERCHA, 2011; WHO 2018). Although the UN's Sustainable Development Goals state that poverty and gender inequality perpetuate HIV transmission, their main focus continues to be on individual behavior change, more or less upholding that the world will be cured of HIV by

talking to individuals one-by-one in “hard to reach places”, so HIV victims can become more aware of risks and prevention methods (UNAIDS, 2018).

This framework illustrates the continuation of the dominant biomedical model that was used to study AIDS in the 1980s, that individuates the disease as a purely scientific problem of viruses and RNA. Again, Fassin illustrates how this construction immediately narrows the social, political, and economic data relevant to discussion (Fassin, 2007). Instead of asking what is the social context under which HIV transmission occurs, international NGOs that diffuse neoliberal governance are concerned only with how individual behavior choice is placing Africans at risk of infection (Fassin, 2007). This epistemology does away with understanding how political violence effects and inhibits individual's ability to choose and reiterates that the AIDS crisis continues because of the customs of native Africans (Fassin, 2007).

The discourse that Africans are too premature to understand the HIV epidemic and rely on the UN and WHO to save them through behavior interventions is incorrect. A study in 2003 conducted by the Swaziland Government found that the Swazi people are highly knowledgeable about HIV, but that this knowledge has not translated into noticeable behavior change. The study concluded that emphasizing behavioral change and education as the most effective means of prevention, only changes the behavior of one in four people and largely only those who are affluent (Mbabane, Government of Swaziland, 2003). Furthermore, a NERCHA report found that basic information on HIV is available to women, but knowledge does not affect their decision to avoid risky sexual behavior, evident in another national survey where 56% of women stated that awareness would not translate into behavior change (Hickel, 2012). Awareness about HIV does nothing to stop people from engaging in risky sexual behaviors when people are dealing with the immediacy of figuring out where to sleep tonight and what to eat tomorrow.

I have argued that the current political economy of South Africa makes HIV transmission impossible to stop. Nationally endorsed neoliberal policies, and global governance institution that diffuse neoliberal ideology, perpetuate the epidemic by increasing levels of inequality that force South Africans to be highly susceptible to contracting HIV. At the same time, the country's subscription to neoliberalism continues the discourse that AIDS can be stopped through an individual, scientific model that ignores these structural problems and allows the epidemic to continue as one of individual responsibility. Although South Africa's political and economic fabric is incomparable with the United States, I have tried to make clear that fighting AIDS requires fighting the neoliberal political economy, regardless of where HIV transmission occurs. Again, in South Africa, this argument is most evident in AIDS activist groups, specifically the TAC, who have drawn heavily from the political ideology and strategy of ACT UP.

Enter Treatment Action Campaign (TAC)

When the Treatment Action Campaign first began its campaign for universal ARVs in 1998, medicine was limited in South Africa, and amidst fierce political struggle and transformation after the end of apartheid in 1994, the threat of HIV was not prioritized (Heywood, 2015). Although by the end of the 1990s medical advances began to turn HIV/AIDS into a chronic, livable disease, the majority of the sick could not afford the medicine. In correlation with the United Nations aim to have "health for all" by 2000, TAC began to develop political strategies that would target western pharmaceutical companies and force them to lower the price of drugs (Heywood, 2015). Here, TAC drew on the strategies of ACT UP, and slowly shifted the epicenter of AIDS activism from predominantly middle class white gay men in the United States, to poor black men and women in South Africa.

While ACT UP in the United States and the TAC both fought against neoliberal governance of HIV by demanding universal health care and immediate access to ARVs for all PWAs, each group faced different obstacles. Although neoliberalism quickly became the dominant global political strategy in the late 20th century, its politics and institutions articulated differently in different places. Particularly for the TAC, their desire to build a mass social movement of the local poor was situated in a post-colony, post-apartheid, young and hopeful democracy, that increasingly subscribed to neoliberal economics while at the same time embodied African nationalism. This is best articulated through Mbeki's association with AIDS denialism. Although in the year 2000 the medical research council released a report stating that 40 percent of deaths of 25 to 40-year-old men and women were caused by AIDS, Mbeki routinely sparked controversy by concluding AIDS could not be caused by a single virus (Nattrass, 2007). Fassin chronicles how Mbeki's discourse that AIDS was a disease of poverty reflects the country's conspiracy-like suspicions as a result of an oppressive apartheid state (Fassin, 2007). This caused anxieties around South Africa being threatened by external and internal forces, leading Mbeki to accuse the TAC of wanting to distribute ARVs throughout the country to murder all poor people (Fassin, 2007). Thus, we are left with a paradox. On one hand, Mbeki used anti-western rhetoric to justify his denial of AIDS. On the other hand, the president reduced tariffs, cut agricultural subsidies, and restructured the public sector through privatization, all strategies in line with neoliberal, western ideology (Magubane, 2004). This simultaneously increased poverty and wealth inequality, something Mbeki and I have argued were a decisive factor in the AIDS crisis, but left PWAs with no access to treatment because of the government's refusal to validate the epidemic. The combination of denialism and neoliberalism evident in Mbeki's administration presented the TAC with a difficult situation to

maneuver, which would require combatting the hidden discursive construction of AIDS while also challenging the president's political and economic ideology.

To fight the myths, fear, and superstition perpetuated by the South African government, the TAC continued to adopt strategies of ACT UP in the United States, while also furthering activist movements that were central in taking down the Apartheid State in 1994. Similarly to the gay community, the TAC chose to strengthen their identification with AIDS. Members of the TAC would introduce themselves by their t-count at meetings, embracing a politics of positivity to end the silence surrounding and AIDS and to humanize the epidemic (Comaroff, 2007). Taking a cue from ACT UP, the TAC also became their own experts of the disease in the face of government denial, in order to create an evidence-based and science-informed understanding of HIV/AIDS (Heywood, 2015). This challenged the biomedical paradigm that casted doctors and scientists as the owners of knowledge on the epidemic. ACT UP activists even traveled to Johannesburg, where they conducted workshops for AIDS activists in South Africa on how to best talk about HIV/AIDS to combat the negative discourses surrounding the disease (Heywood, 2015). By marketing themselves as scholars on the AIDS crisis, PWAs in South Africa did not have to subscribe to derogatory discourses arising from the individuation of the disease, and instead could challenge policy makers, health workers, and pharmaceutical companies on their desires to acquire comprehensive treatment.

The TAC also strengthened their campaign by organizing with members of the Congress of South African Trade Unions (COSATU). In contrast to neoliberal governance bodies, by aligning themselves with the trade union movement, the TAC illustrated the importance of centering problems of political economy to combat the AIDS epidemic (Heywood, 2015). This coalition mirrored other solidarity movements that formed during the apartheid in South Africa,

revealing how the same activists who wanted an end to a fascist state were also united in confronting the spread of HIV as a serious public health problem. At the same time, the partnership between the TAC and COSATU strengthened their argument that the spread of HIV was a consequence of the capitalist industry that entrenched South Africans into systems of labor migration, and consequently caused an increase in poverty, unemployment, and sex work. Furthermore, this stance allowed the TAC to reveal how Mbeki's neoliberal policies were increasing poverty in the country and allowed for greater incentive to mobilize a working-class movement that was against AIDS, one that again mirrored movements active during the apartheid regime. Highlighting the link between HIV transmission and mine workers, and working conditions and exchange of money for sex, also supports Fassin's argument that controlling the spread of AIDS is not a sole matter of changing individual health services, but also changing the pattern of oppressive working conditions (Fassin, 2007).

In July of 2002, the coalition between the TAC and COSATU came to a turning point when representatives tabled a resolution calling for a National Treatment Plan that would guarantee all PWAs access to ARVs and healthcare (Nattrass, 2007). Not surprisingly, Manto Tshabalala-Msimang, South African Health Minister and another controversial figure aligned with AIDS denialism, refused to endorse the agreement (Nattrass, 2007). In response, 15,000 people marched on parliament during Mbeki's State of the Nation Address, to demand the government implement the AIDS prevention and treatment plan. When Mbeki refused to acknowledge the plan, the TAC turned to direct action. On March 20th, 2003, the TAC launched a several months long civil disobedience campaign that centered on demonstrations, occupations, and disruption (Heywood, 2015). Drawing a similar response to the demonstration put on by ACT UP, the campaign sparked media attention worldwide and became increasingly

embarrassing for the government. When the ANC recognized its power was beginning to slip, Mbeki's cabinet revolted against his denialism, and declared that the government would commence distributing highly active ARVs in 2004 (Nattrass, 2007).

More than a decade later, the TAC direct action's targeting Mbeki's denialism and neoliberal policies have led to tangible victories for PWAs in South Africa. In 2015, 2.4 million people were on ARV treatment in South Africa, and the cost of ARVS was under $100 per patient per year, compared to $7,000 per patient per year in the 1990s (Heywood, 2015). The parallels and success shared between ACT UP and the TAC validate the importance of AIDS activism in confronting neoliberal economic policies to reduce rates of HIV transmission. While the two movements grew out of frustration from different marginalized people among different social, political, and economic contexts, their solidarity and shared strategies to challenge discursive construction of AIDS, highlight the need for continued scrutiny of neoliberal governance, even if its diffused behind "humanitarian" NGOs and world governance organizations.

CONCLUSION

In this paper, I have argued that the individual, biomedical, neoliberal framework that has dominated the fight to end AIDS, both past and present, north and south, discursive and grounded, is insufficient. Battling the HIV epidemic must require battling neoliberal policies that govern prevention campaigns; it must require recognizing individuals as defenseless against structural problems, and it must require fighting against racist, homophobic, classist discourses that cast victims of HIV as mute, barbaric, and backward. Recognizing the HIV epidemic as a catastrophe of intersectional oppressions, specific political agendas, and abuses of power is the

only way to prevent the epidemic from worsening in the face of climate change accelerating, undoubtedly creating new structural problems and increased levels of poverty and migration.

While I have suggested that multi-faced, ascending activist groups have done the most impressive work to stop the global AIDS crisis, HIV/AIDS is still a leading cause of death in the world. I will not entertain the idea that I can synthesize an all-encompassing, totalizing, fixed truth that will lead us going forward in stopping the epidemic. But in conclusion, I hope to contribute to scholarship that advocates for forgetting about our predominant, neoliberal view of HIV/AIDS that fetishizes biomedical individualism, and instead establish AIDS in terms of Fee and Krieger's Paradigm of a "Collective, Chronic, Infectious Disease and Persistent Pandemic." In line with my wishes to connect the divide between theory and praxis, political theory and political activism, I want to briefly explain how this model fits the strategies of the Brazilian AIDS Social Movement (BASM), one of the most effective AIDS activist campaigns.

First and foremost, Fee and Krieger articulate that establishing an alternative paradigm require recognizing that AIDS is not an individual matter, but rather a collective, societal problem that is the consequence of personal relationships that take place within a social context (Fee et Al, 1993). Secondly, discourses that spew AIDS as a plague, whether of gay or black bodies, denote a need for isolation and otherness. Addressing HIV as an infectious and chronic disease without attached metaphors of anxiety, will help eradicate stigma against PWAs and put more attention on the need for universal health care and easy access to treatment. Finally, articulating consistently that AIDS is a persistent pandemic that needs long term solutions, and requires global engagement and solidarity, such as the alliance between ACT UP and the TAC, will accelerate our chances of curbing transmission rates. This is shouted by many activists, such

as South African Adam Levin, who say “the world has AIDS. And if you give a shit about the world, you have it too.” (Comaroff, 2007).

While I have only focused on the AIDS movements in the United States and South Africa in the paper, Brazil presents an example of how this alternative paradigm can successfully truncate the epidemic. In 1990, the World Bank estimated that by 2000, Brazil would have over 1.2 million people testing HIV positive, but the actual number came to only 600,00, a 50% drop in the mortality rate (Ernesto, 2003). This drastic decrease in HIV infection is largely because of the Brazilian AIDS Social Movement (BASM) during the 1980s and 90s that did not focus on individual prevention, but recognized HIV transmission as an intersectional, societal issue caused by political and economic structures (Hickel, 2012). The campaign successfully fought for each citizen’s constitutional right to health care and antiretroviral therapies, while also confronting social inequalities, corporate class power, and military might. The movement also created a partnership between the government and grassroots campaigns, which increased the visibility of victims to illustrate what those people actually needed form the government to prevent infection (Ernesto, 2003). Mass social movements that attack the political economy of the state, and link solidarity with power, reveal the effect these movements can have in ending HIV transmission. Although a different response than the neoliberal global governance institutions, the UN has stated that the country’s prevention and treatment campaigns are the most successful in the Global South, resulting in infections rates today hovering around .5% of the adult population (Reel, 2006; AVERT, 2018).

Brazil illustrates an example of how transforming our historical understanding of AIDS can allow us to establish new policies and prevention methods that are relevant in stopping the epidemic. While Brazil provides us an exciting example, combatting the global discursive

construction and neoliberal governance of AIDS will not be an easy task. Brazil is only one country with one political history, economy, and social context that differs greatly from the epicenter of the epidemic in South Africa. But if we can create a new discourse that the AIDS crisis will not stop until structural barriers, ranging from colonial legacies of scientific racism to neoliberal policies of deregulation, are contained, we can begin to challenge the conventional, safe, apolitical, atemporal view of AIDS. The fight against HIV/AIDS belongs to all of us who imagine ourselves to be globally engaged citizens. Following the examples of AIDS activists in the United States and South Africa, it is clear that creating a massive AIDS social movement can give us the power to own the disease, its construction, prevention campaigns, and deaths. This recognition will strengthen the fight against the deprecatory discourses of the epidemic, highlighting the need to challenge neoliberal policies that deepen vulnerability to transmission and continue to present PWAs as separate from their place in the political economy.

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